PRIOR AUTHORIZATION REQUEST
WOUND HEALING AGENTS

Patient's Name_____9 Digit IDPA Recipient# _____
Patient's DOB_____ Pt's. SSN_____
***(*_If Applicable_*)**
***LTC Facility Name_____LTC Facility Tel.#_____**
***Admission Date To Facility_____**
Treatment Nurse Trained In Wound Care? [ ] Yes [ ] No
Physician's Name_____DEA #_____

Patient's Nutritional Status: [ ] Good [ ] Fair [ ] Poor
List other factors that adversely affect wound healing: (e.g.:Circulatory Insufficiency – Drug Therapy – Urine/Stool Incontinence with skin exposure – Immobility – etc)_____

****_Indicates Wound Information Which Must Be Shown or Form Will Be Returned - If Unknown Indicate_ ?**

****Wound Location_____ Duration : # ___Days ___Wks. ___Mos.**

****Type Of Wound: [ ] Pressure Ulcer [ ] Venous Stasis Ulcer [ ] Diabetic Ulcer [ ] Excoriation [ ] Other - Describe:_____**

****Largest Known Size in Cm.:Length_____Width_____Depth_____Date_____**
****Present Size in Cm : Length_____Width_____ Depth_____ Date_____**

****Amount of devitalized tissue (Slough) remaining _____%**

Is (Are) Wound(s) Infected? [ ] Yes [ ] No

Is Wound Infection Being Treated? [ ] Yes [ ] No

DESCRIBE OTHER WOUNDS ON ANOTHER SHEET.

Name of Drug:_____NDC Number_____

Pharmacy Name _____Tel.#_____-_____-_____

Pharmacy Provider Number_____
Comments:_____

INFORMATION MUST BE COMPLETE OR APPROVAL WILL NOT BE GIVEN

PLEASE FAX TO: 217-524-7264 ATTN: MEDICAL COMMITTEE

This Information is Confidential and for informational use only by Department Personnel Involved In The Prior Approval Process. **Revised 03/17/03**